

A COMPLETE SERIES OF CLINICAL CHARTS FOR KEEPING THE RECORDS OF SUR- GICAL CASES.

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THOSE who are compiling statistics or making inquiry into particular phases of certain subjects know how tedious and time-consuming a task it is to sift out the data that bear directly upon the subject of the investigation. If these facts were arranged and classified in a systematic manner, their task would be immensely lightened. With this idea in view, I have compiled five clinical charts, which are used in the surgical service of the University Hospital: (1) a History and Treatment Record; (2) an Anæsthesia Record; (3) a Nurse's Record; (4) a Temperature Record; (5) a Pathological, Bacteriological, Blood, and Urine Record.

These Record Sheets are of the same dimensions and have each a margin of the same width, in order that they may be bound together. Two of the five have been so designed that the records may be written upon both sides of the sheet, not so much for the sake of economizing in paper, but more particularly for the sake of economizing in space and condensing the matter into the fewest number of pages. On the heading of every sheet space is provided for the patient's name, the index file number, and the number of the volume in which this particular history will be found.

(1) *History and Treatment Record*.—At the top of the sheet space is allowed for the filling in of a number of data that will be frequently referred to, and which, if not isolated, must

be tediously searched for in the text of the history. Thus, the age and address of the patient, the age and address of the physician by whom the patient was referred, the diagnosis, the character and date of the operation, the character of ligature or of suture material used, the introduction and withdrawal of

HISTORY AND TREATMENT RECORD.				
Name	Mr. J. G. Z.	Hospital	University	Index File No. 235 Vol. III
Age	19	Address	University Dormitories	Service of Dr. Frazier
Date of Admission	July 5, 1900	Date of Discharge		
Referred by Dr.	Alfred Stengel	Address	1611 Spruce St., Philadelphia.	
Diagnosis	Recurrent Appendicitis			
Operation	Appendectomy	Date	July 7, 1900.	
Ligature Material	Catgut	Suture Material	Buried- Catgut	Drainage None
Character of Dressing	Sterile gauze and cotton		Cutaneous silk worm gut.	
Drainage Removed		Sutures Removed	July 17, 1900	Freq. of Dressing "Once a week.
Skidograph No.		Date		Result
Date	7-7-00	The patient was transferred from the Medical to the Surgical Ward of the Hospital, having just recovered from his third attack of appendicitis. (For previous history, see records in Medical Ward.) Operation in the interval; McBurney's incision. Appendix delivered through the wound without any difficulty. Mesentery ligated. Appendix ligated close to caecum with silk ligature. Purse-string suture introduced into caecum around the base of the appendix; stump of the latter inverted and suture drawn fast. Peritoneum and transversalis fascia, the internal and external oblique muscles, closed with buried catgut sutures; skin and cellular tissue, with interrupted silkworm-gut sutures. 7-8 Patient was somewhat shocked after the operation and required some stimulation. This evening the abdomen is soft, and peristalsis is active. Complaints of some little pain at seat of operation. 7-9 One grain of calomel in divided doses, followed by Epsom salts, was ineffectual. Bowels moved freely after the administration of an enema. 7-14 Abdominal wound dressed today for the first time. Wound has healed throughout by first intention. One-half of the stitches were removed. Patient given soft diet. 7-17 Remaining stitches removed at second dressing today. 7-18 Patient complained today for the first time of pain over the femoral vein. Examination proved it to be due to a phlebitis. This accounts for the increase in leucocytes noted in blood-count of this date. Leg enveloped in lead-water and bandannum elevated and placed in fracture-box.		

drainage, the frequency of subsequent dressings, and the date at which the sutures were removed, are given; finally, space is allowed for a record of the skidograph, if one is taken.

Then follow the history and examination of the case, the subsequent ward notes, including a description of the

operation, which may be written up by the operator or the registrar. Both sides of the sheet are ruled, so that the history may be continued on the other side.

(2) *The Anæsthesia Chart* is modelled after the one in use in the Gynæcological Wards of the University Hospital in

ANESTHESIA AND OPERATION RECORD.		
NAME <i>Mr. J. G. E.</i>	HOSPITAL <i>University Hospital</i>	FILE NO. <i>335</i> VOL. <i>77</i>
ANESTHESIA CHART.		
Operation <i>Appendectomy</i>	Date <i>July 7, 1900</i>	Operator <i>Dr. Frazier</i>
Operation Started <i>1:10 P.M.</i>	Operation Ended <i>1:50 P.M.</i>	
Anæsthetic		
Variety <i>Ether</i>	Method <i>Allis inhaler</i>	Anæsthetic <i>Dr. Ather</i>
Time to Anæsthetic <i>10 minutes</i>	Am't to Anæsthetic <i>2 ounces</i>	Total Am't Used <i>4 ozs.</i>
Examination of Chest (before) <i>Negative</i>		
" " " (after) <i>"</i>		
Treatment on Table <i>Stimulant Strychnine sulph. gr. 1/50 hypodermically.</i> Normal Saline Solution Method of Introduction Amount Introduced Oxygen General condition of patient at time of operation <i>Good.</i> REMARKS		

the service of Dr. Clark. Apart from the valuable statistics upon anæsthesia which a large series of these charts furnish, they are of additional value in that they keep the attention of the anæsthetizer constantly on his patient. The pulse rate,

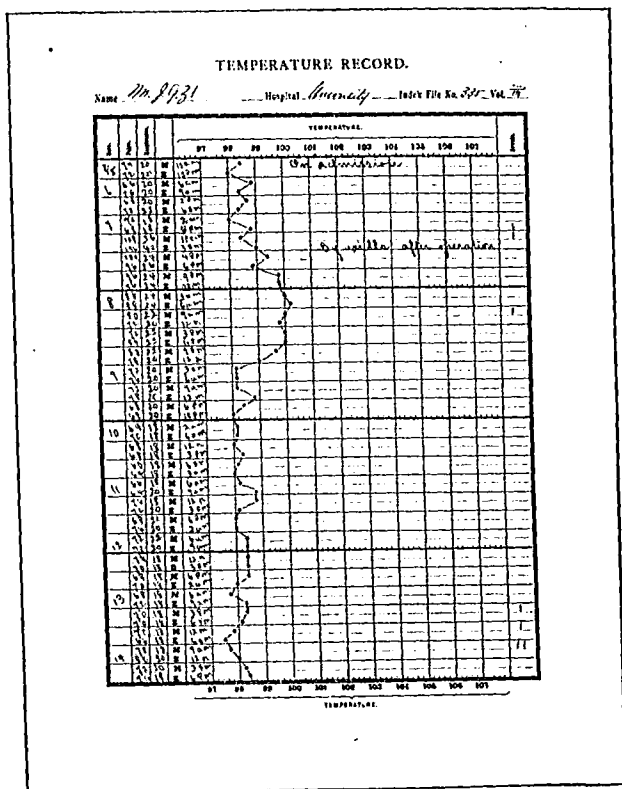
which is taken every five or ten minutes, is represented by a tracing upon the chart, while the rate of respiration is recorded in numerals at the foot. In addition to filling out the chart itself, it is the duty of the anæsthetizer to record other facts

NURSES' RECORD.														
NAME Mr. J. G. Z.			HOSPITAL University					INSTR. EX. No. 355			Vol. 111			
TIME	LOC.	POS.	TEMP.	PULSE	RES.	SP. O ₂	SP. CO ₂	SP. P ₁₀	SP. P ₅₀	SP. P ₁₀₀	SP. P ₁₅₀	SP. P ₂₀₀	SP. P ₂₅₀	REMARKS
1900														
7-7	6.00 AM	98.8	68	18	3vi									First trace 3vi
7-7	10.00	98.4	101	56										
7-7	1.30 PM	98.4	112	37	3vi									
7-7	3.00	98	116	40										Respiration 1/2 of trace, 3/4
7-7	6.00	98.4	104	24										
7-7	6.00	98.5	76	26										
7-7	7.00	98.8	76	26	3R									
7-7	12.10 AM	99.8	76	24										
7-8	3.00 AM	100	88	24										
7-8	6.00	100.2	88	24	3V									
Total	24 hours													
7-8	9.00 AM	100	80	22	3vi									
7-8	11.00													
7-8	12.00	99.8	72	20										
7-8	1.00 PM													
7-8	2.00													
7-8	3.00													
7-8	4.00													
7-8	5.00													
7-8	6.00	99.8	84	34	3iv									
7-8	7.00													
7-8	8.00													
7-8	9.00	98.6	80	22										
7-8	10.00													
7-8	11.00													
7-8	12.00	98	76	24										
7-9	1.00 AM													
7-9	2.00 AM													
7-9	3.00	98.2	72	20										
7-9	4.00													
Summary														
None at Name														

relative to the condition of the patient before, during, and after the operation; the duration of the operation; the time and the amount of anæsthetic required to fully anæsthetize the patient, and the total amount used; the treatment, if any,

carried out upon the table (e.g., hypodermic, stimulating, the use of normal saline solution, inhalation of oxygen, etc.).

(3) *The Nurse's Record* contains columns in which to record the temperature, pulse, and respiration; the urine and stools; medicine and stimulants; character and amount of



nourishment, and the amount of water the patient has drunk. Provision is not usually made in clinical sheets for recording this information; and yet it is quite as important sometimes to know how much water the patient has drunk as it is to know how much he has eaten.

and condition of his case during the past twenty-four hours, and can make, if he so chooses, without any difficulty, a comparison of the condition of one day with that of another.

(4) *The Temperature Record* is one which has been in

PATHOLOGICAL RECORD.			
Name	Mr. J. G. Z.	Hospital	University
Index File No.	335	Vol.	
Specimen of an appendix with little or no mesenteric attachment.			
Pathological Diagnosis Chronic Interstitial Appendicitis.			
Microscopic Description The appendix measures three and one quarter centimetres in length; .5 centimetres in diameter at its proximal portion, and .9 centimetres at its distal portion. The walls of the appendix are thicker and more resistant than normal and feel somewhat indurated. The lumen is filled with an exudate which is mucopurulent in character. The blood-vessels are markedly distended, especially in the distal portion.			
Microscopic Description The section taken for examination is from the proximal end. The mucosa, submucosa, muscularis and serosa all give evidence of previous inflammatory disturbance. All the coats especially the serous are thicker than normal. There are several hemorrhagic areas in the mucosa and submucosa and immediately beneath the serous coat. The epithelial lining of the mucosa and the glandular elements has almost entirely disappeared. Connective tissue is present to some extent in all the layers. The mucosa and submucosa are the seat of a very active infiltration of round cells and at one or two places small interstitial abscesses have formed. The blood-vessels are dilated and their walls considerably thickened.			
BACTERIOLOGICAL RECORD.			
Specimen of mucopurulent secretion from cavity of appendix.			
Bacteriological examination gave pure cultures of <i>Bacillus pyocyaneus</i> .			

use in the Surgical Service of the University Hospital for some time, and calls for no especial comment.

(5) Upon one side of the last sheet is entered the *Pathological and Bacteriological Report* upon its receipt from the laboratory of the pathologist or bacteriologist to whom the

specimen has been referred. The frequency with which one finds himself turning to one or the other of these laboratories for information warrants the reservation of at least one page for these reports. The undoubted value of the blood count in the diagnosis of surgical affections makes it almost imperative that one should take advantage of the information to be gathered from this source. A table has therefore been included in which a dozen or more blood counts may be entered. A urinalysis table concludes the series.